SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Filing at a Glance

Company: Bankers Life and Casualty Company

Product Name: L-18270	SERFF Tr Num: BNLA-127202721	State: Arkansas
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed-Approved-Closed	State Tr Num: 49101
Sub-TOI: L09I.001 Single Life	Co Tr Num: L-18270	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Dan Murphy, Sandra Pufpaf, Sue Novotny	Disposition Date: 06/23/2011
	Date Submitted: 06/21/2011	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: L-18270	Status of Filing in Domicile: Pending
Project Number: L-18270	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 06/23/2011
	State Status Changed: 06/23/2011
Deemer Date:	Created By: Sandra Pufpaf
Submitted By: Dan Murphy	Corresponding Filing Tracking Number:

Filing Description:

Insurance Department Personnel

NAIC 233-61263 FEIN 36-0770740

RE: Individual Life Insurance - New Form
Fully Underwritten Life Insurance Application
Application Form L-18270-AR

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Dear Sir/Madam:

We are filing the above referenced application form for your consideration and approval. This filing contains no unusual or controversial items from normal Company or industry standards. This form is new and not intended to replace any existing policy forms.

This form is designed to be used by our agents in your state to solicit our previously approved life insurance policies. This form may be used in both paper and electronic formats. When used in an electronic format, the spacing and font may vary from the paper format, but the text and order of the application will not change.

We request that you allow us to file the Company address, Sections 1. Policy Information, 1.C. Additional Benefits Applied For, and 13. Proposed Insured's Acknowledgment of Notices, as variable so we can use this application with any future policy forms or notices that may be developed or required and show the current address on the application. These sections would be the only variable information in the application.

The Flesch Test Readability score for application form L-18270-AR is 50.64.

This form has been filed in the Company’s home state of Illinois and is currently pending approval.

We respectfully request your favorable consideration and approval of this filing. If you have any questions or need additional information, please feel free to contact me. My contact information is shown below.

Company and Contact

Filing Contact Information

Dan Murphy, Compliance Administrator	d.murphy@banklife.com	
600 West Chicago Ave	312-396-6134 [Phone]	
Chicago, IL 60654-2800	312-396-5907 [FAX]	

Filing Company Information

Bankers Life and Casualty Company	CoCode: 61263	State of Domicile: Illinois
600 West Chicago Ave	Group Code: 233	Company Type:
Chicago, IL 60654-2800	Group Name:	State ID Number:
(800) 621-3724 ext. [Phone]	FEIN Number: 36-0770740	

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
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TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 form @ $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bankers Life and Casualty Company	$50.00	06/21/2011	48945048

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/23/2011	06/23/2011

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
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Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Disposition

Disposition Date: 06/23/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
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Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	Application		Yes

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
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Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Form Schedule

Lead Form Number: L-18270

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-18270-AR	Application/ Enrollment Form	Application	Initial		50.640	L18270-AR.pdf

APPLICATION FOR INSURANCE

BANKERS LIFE AND CASUALTY COMPANY("The Company")
600 West Chicago Ave, Chicago, IL 60654-2800

(PLEASE CLEARLY PRINT ALL INFORMATION)

1. Policy Information ○ **L-19E** ○ **L-20E** ○ Other _____

A. **Death Benefit Amount/Options** **Proposed Insured** $_____ ○ A (Level Benefit) ○ B (Increasing Benefit)

B. **Universal Life Waiver Riders** ○ None ○ Waiver of Cost of Insurance ○ Waiver of Planned Premium

C. **Additional Benefits Applied For** (1 Unit equals $1,000.00)

☐ Accidental Death _____ Units ☐ Additional Insured Term Insurance _____ Units

☐ Term Insurance _____ Units ☐ Children Term Insurance _____ Units

☐ Disability Income Insurance **(Complete Required Form)** ☐ Other _____ ☐ Other _____

Credit Option Allocation **(L-19E Only)** - Indicate percentages to Accumulation Values - Available 5% allocations totaling 100%

___% Fixed Rate

___% S&P 500® Index One-Year Monthly Averaging with Participation Rate Strategy

___% S&P 500® Index One-Year Point-to-Point with Cap Strategy

D. **Frequency of Premiums To Be Paid**

○ Annually ○ Quarterly ○ Semi-Annually ○ Payroll Deduction

○ Premium Payment Service Plan/Monthly Bank Draft **(Complete Required Form)**

Planned Modal Premium $_____ Lump Sum Premium $_____

E. **Requested Special Issue Date** (mm-dd-yyyy) _____ - _____ - _____

2. A. **Personal Information of Person to be Insured**

_____ ___ _____ _____

Proposed Insured's First Name M.I. Last Name Suffix

Gender: ○ M ○ F Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced ○ Other _____

_____ - _____ - _____ _____ ___ ' ___ " _____

Date of Birth (mm-dd-yyyy) Age Height (Feet and Inches) Weight (Pounds)

Social Security Number _____ - _____ - _____ State/Country of Birth _____

Driver's License Number _____ State of Issue _____

B. **Personal Information of Additional Proposed Insureds**

	Name	SSN/Driver's License Number	Gender & DOB	Marital Status	Height/Weight	State/Country of Birth	Relationship to Proposed Insured
2							
3							
4							
5							
6							

3. Contact Information of Proposed Insured

A. Home Address

_____ _____ _____ - _____

City/Town State Zip Code

_____ - _____ - _____ _____ - _____ - _____

Home Phone Work/Cell Phone

B. Billing Address (if different than home address)

_____ _____ _____ - _____

City/Town State Zip Code

4. Owner/Payor Information (Do not complete if the Owner/Payor is the Proposed Insured)

A. Owner's/Payor's First Name _____ M.I. _____ Last Name _____ Suffix _____

Relationship to Proposed Insured _____

Date of Birth or Trust Date (mm-dd-yyyy) _____ - _____ - _____ Age _____ ○ Social Security Number ○ TIN ○ EIN _____

B. **Owner's/Payor's Home Address** ○ Select if the same as Proposed Insured's address. If so, do not complete Payor's address.

Street Address _____ City/Town _____ State _____ Zip Code _____ - _____

Home Phone _____ - _____ - _____ Work/Cell Phone _____ - _____ - _____

5. Existing Coverage

A. List all existing and applied for life(L), annuity(A), health(H), disability income(DI) and long-term care insurance(LTC).

Insurance Company	Policy Type	Policy #	Coverage Amount	Accidental Death Benefit Amount	Year Issued	Insured	Will be Replaced?	1035 Exchange?

B. **Existing Coverage and Replacement Information**

(1) Does any proposed insured have any existing life or annuity coverage with any company? ○ Yes ○ No

(2) Is the policy now applied for intended to, or likely to, replace or change any existing life or annuity coverage? ○ Yes ○ No

(3) Will any coverage replace any existing Bankers' policy or certificate? ○ Yes ○ No

6. Beneficiary Designation (If there is more than one Beneficiary in a class, We will pay benefits to them in equal shares, unless otherwise indicated in the Beneficiary Remarks Section.)

P = Primary/ C = Contingent	Name	Relationship	Address
● P / ○ C			
○ P / ○ C			
○ P / ○ C			
○ P / ○ C			

Beneficiary Remarks: _____

7. Financial Information/Employment Information for Proposed Insured

1. Name of Employer/Length of Employment _____

   Business Address _____ Street Address City State Zip Code

2. Annual Earned Income $_____ 3. Net Worth $_____

4. Describe Duties _____

5. Income From All Other Sources $_____

8. Qualifying Questions Please detail all "Yes" answers in Section 10. Additional information may be requested	Proposed Insured		Additional Proposed Insured		Dependent/ Children	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
If answer to Questions 8A. or 8B., is answered "Yes", the Proposed Insured is not eligible for any coverage. Do not submit application.						
A. Has any proposed insured been diagnosed with, received treatment for, or advised to seek treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or a positive test for the Human Immunodeficiency Virus (HIV)?.	○	○	○	○	○	○
B. Has any proposed insured ever been diagnosed with, treated for, or consulted a medical professional for Alzheimer's Disease or any dementia or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	○	○	○	○	○	○
If answer to Questions 8C. or 8D., is answered "Yes", agent should not collect any money on this application.						
C. Has or is any proposed insured:						
1. Ever been convicted of, or currently charged with, the commission of a crime, other than a traffic offense? If yes, provide date, offense, location and disposition.	○	○	○	○	○	○
2. Been convicted of a felony, reckless driving, or driving under the influence of drugs or alcohol, or had their license suspended or revoked, or in the last three years had more than two moving traffic violations or accidents?	○	○	○	○	○	○
3. Ever used or is currently using, cocaine, marijuana, heroin, amphetamines, barbiturates or other drugs except as prescribed by a physician?	○	○	○	○	○	○
D. Has any proposed insured ever been diagnosed with, treated for, or consulted a medical professional for:						
1. Chest pain, heart attack, coronary artery disease, heart murmur, congestive heart failure, or any disorder of the heart?.	○	○	○	○	○	○
2. Stroke, transient ischemic attack or disorder of the blood vessels of the neck or brain?	○	○	○	○	○	○
3. Cancer, tumor, leukemia, melanoma, Hodgkin's disease or lymphoma?	○	○	○	○	○	○
4. Organ transplant?	○	○	○	○	○	○
5. Had or been advised to have treatment or counseling for alcohol or drug abuse?	○	○	○	○	○	○
E. Has any proposed insured ever been diagnosed with, treated for, or consulted a medical professional for:						
1. Disorder of the aorta, arteries, veins or blood vessels, high blood pressure or hypertension? . . .	○	○	○	○	○	○
2. Diabetes or high blood sugar, any disorder of the kidneys, genital or urinary tract or renal failure?	○	○	○	○	○	○
3. Any sexually transmitted disease?	○	○	○	○	○	○
4. Asthma, emphysema, cystic fibrosis, Chronic Obstructive Pulmonary Disease (COPD), sleep apnea or any disorder of the lungs or respiratory tract?	○	○	○	○	○	○
5. Seizure disorder or any disorder of the brain or nervous system?	○	○	○	○	○	○
6. Hepatitis, cirrhosis, ulcerative colitis, or any disorder of the liver, stomach, intestines or digestive tract?	○	○	○	○	○	○
7. Depression, anxiety, schizophrenia, any mental or psychiatric disorder, alcohol abuse or drug abuse?	○	○	○	○	○	○
F. Within the last five years has any proposed insured:						
1. Engaged in scuba diving, parachuting, mountain climbing, gliding, hang gliding, operating an ultra-light aircraft, engaged in land or water vehicle racing or any other hazardous sport?	○	○	○	○	○	○
2. Operated or had duties on an aircraft?	○	○	○	○	○	○
3. Been a patient in a hospital, long-term care facility, nursing home or medical facility?.	○	○	○	○	○	○
4. Had or been advised to have, surgery, electro cardiograms, stress tests, blood tests, urine analysis, MRI (Magnetic Resonance Imaging) or CT (Computed Tomography) scans, or any medical tests or diagnostic procedures?	○	○	○	○	○	○
5. Consulted a physician, clinical psychologist or counselor?	○	○	○	○	○	○
G. Within the last 24 months has any proposed insured:						
1. Ever used tobacco or nicotine products such as cigarettes, cigars, chewing tobacco, snuff, nicotine gum, or nicotine patch? If yes, provide type, amount and date last used.	○	○	○	○	○	○
2. Traveled or plan to travel outside the United States or Canada?	○	○	○	○	○	○

8. Qualifying Questions Please detail all "Yes" answers in Section 10. (Continued)	Proposed Insured		Additional Proposed Insured		Dependent/ Children	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
H. Within the last 12 months has any proposed insured:						
1. Been unable to perform his or her normal daily activities or occupational duties?	○	○	○	○	○	○
2. Had a weight loss or gain of more than 10 pounds?	○	○	○	○	○	○
I. Has any proposed insured ever had life or health insurance declined, postponed or issued with an increased premium or decreased benefits, or received disability benefits?	○	○	○	○	○	○
J. Has any immediate family member of any proposed insured died from or had an occurrence of cardiovascular disease, cancer, diabetes or cerebrovascular disease prior to age 60?	○	○	○	○	○	○
K. Is any proposed insured **NOT** currently a US citizen? If **NOT**, provide Visa number, expiration date or Permanent residence (Green Card) number.	○	○	○	○	○	○

PLEASE SEE INSTRUCTIONS FOR "YES" ANSWERS IN SECTION 10

9. Primary Care Physician Information

	Primary Insured	Additional Insured	Children
Name of personal physician:			
Address:			
Telephone:			
Date & Reason Last Consulted:			

10. Details to Medical Questions

Proposed Insured	Please detail all "Yes" answers, for each Proposed Insured, from Question 8 in the space provided below including all applicable dates and durations, treatment, medications and any advice given by physician or medical professional. Provide full name, mailing address and phone numbers. We may request additional information. ○ Check if name, mailing address and phone numbers provided under Question 9

11. General Remarks: _____

12. Acknowledgments

THE PROPOSED INSURED(S), EACH TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, REPRESENT AND AGREE AS FOLLOWS:

A. I have read, or had read to me, the completed application and realize that any false material statements or misrepresentation in this application may result in loss of coverage under the policy.
B. The statements in this application concerning past and present health are complete, true and correct.
C. No agent is authorized to waive or modify any terms of this application. An agent's knowledge of any facts not disclosed in this application will not be considered knowledge by the Company nor be binding on the Company.
D. No agent, medical examiner or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
E. Any insurance policy issued as a result of this application shall, together with the application, constitute a single and entire contract of insurance.
F. If premium was paid with this application, I have read the receipt given to me and fully understand the conditions and limitations stated in the receipt and that no agent can waive or change such conditions and limitations.
G. Any insurance issued as a result of this application will either: (i) not take effect for each person proposed for insurance unless and until the full first premium is paid and the policy is delivered during such person's lifetime and while such person is in the condition of health set forth in this application; or (ii) take effect only as specified in the receipt, if any, attached to this application.
H. Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan applied for have been explained and are understood.
I. The proposed insured shall be the owner of any insurance applied for unless otherwise requested.

13. Proposed Insured's Acknowledgment of Notices

The proposed insured has received and acknowledges receipt of the following forms:

- Privacy Notice
- Conditional Receipt (if applicable)
- Notice Regarding Replacement Form (if applicable)

14. Signatures

I understand the agent(s) represents, provides services on behalf of and is compensated by Bankers Lifeand Casualty Company. I certify that the statements contained in the application are complete, true and correct to the best of my knowledge.

_____ _____ _____ - _____

Dated at City/Town State Zip Code

This _____ Day of _____ 20 _____

Signature of Proposed Insured X _____

Signature of Proposed Insured 2 X _____

Signature of Additional Proposed Insured (if age of majority) X _____

Signature of Owner X _____

I have witnessed the signature of the Proposed Insured and Other Proposed Insured(s), if also applying. I certify that I asked all the applicable questions and truly and accurately recorded the answers contained herein. I certify that the Proposed Insured has read the completed application or had it read to him or her. To the best of my knowledge and belief, except as may be stated by the Proposed Insured's response to Question 5.B., the insurance applied for is not, or is not likely, to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X _____ Agent No. _____ _____%

Branch Office Number _____

Signature of Licensed Resident Agent X _____ Agent No. _____ _____%

Branch Office Number _____

MAKE ALL CHECKS PAYABLE ONLY TO BANKERS LIFE AND CASUALTY COMPANY

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SERFF Tracking Number:	*BNLA-127202721*	*State:*	*Arkansas*
Filing Company:	*Bankers Life and Casualty Company*	*State Tracking Number:*	*49101*
Company Tracking Number:	*L-18270*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*L-18270*		
Project Name/Number:	*L-18270/L-18270*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
AR Cert.pdf
READABILITY CERTIFICATION.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Please see forms schedule.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: Not Applicable - Life Application Filing Only
Comments:

Item Status: **Status Date:**

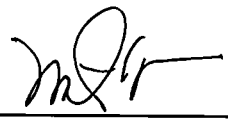
Bypassed - Item: Outline of Coverage
Bypass Reason: Not Applicable - Life Application Filing Only
Comments:

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: **Bankers Life and Casualty Company**

Form
Number(s):
L-18270-AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19 in regards to Unfair Sex Discrimination in the Sale of Insurance..



Signature of Company Officer

Mathias E. Brown
Name

Assistant Secretary
Title

June 21, 2011
Date

READABILITY CERTIFICATION

Company Name: Bankers Life and Casualty Company

NAIC Number: 233-61263

As an officer of Bankers Life and Casualty Company, I hereby certify that the below captioned form achieved the following readability score as calculated by the Flesch Reading Ease Test and that this form met the reading ease requirements in your state.

Flesch Score	Form Number	Description
50.64	L-18270	Application for Life Insurance

_____ 06/03/2011

Mathias E. Brown DATE

Assistant Secretary